Bureau of Health Care Quality and Compliance

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVN5907ADC	A. BUILDING _____ B. WING _____	06/03/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MORE TO LIFE ADULT DAY HEALTH CENTER, LLC	1963 E PRATER WAY SPARKS, NV 89434

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
U 000	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of the initial State Licensure survey conducted at your facility on 6/3/10. The survey was conducted using Nevada Administrative Code (NAC) 449, Facilities For Care Of Adults During The Day, regulations adopted by the Nevada State Board of Health on June 23, 1986. The facility has applied for a license as a 40-client Adult Day Care Facility. The census at the time of the survey was zero. One (1) sample resident file was reviewed and two employee files were reviewed. The facility was found to be in substantial compliance with the regulations regarding this survey. No further action is necessary concerning this report. Please retain this copy for your records.	U 000		

If deficiencies are cited, an approved plan of correction must be returned within 10 days after receipt of this statement of deficiencies.

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE